

accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period. The intermediary reviews the request and forwards it, with a recommendation for approval or denial, to HCFA central office within 30 days of receipt of the request. HCFA central office either approves or denies the request and notifies the intermediary within 60 days of receipt of the request.

(5) An acceptable cost report submission is defined as follows:

(i) All providers—The provider, must complete and submit the required cost reporting forms, including all necessary signatures. A cost report is rejected for lack of supporting documentation only if it does not include the Provider Cost Reimbursement Questionnaire. Additionally, a cost report for a teaching hospital is rejected for lack of supporting documentation if the cost report does not include a copy of the Intern and Resident Information System diskette.

(ii) For providers that are required to file electronic cost reports—In addition to the requirements of paragraphs (f)(4) and (f)(5)(i) of this section, the provider must submit its cost reports in an electronic cost report format in conformance with the requirements contained in the Electronic Cost Report (ECR) Specifications Manual (unless the provider has received an exemption from HCFA).

(iii) The intermediary makes a determination of acceptability within 30 days of receipt of the provider's cost report. If the cost report is considered unacceptable, the intermediary returns the cost report with a letter explaining the reasons for the rejection. When the

cost report is rejected, it is deemed an unacceptable submission and treated as if a report had never been filed.

(g) *Exception from full cost reporting for lack of program utilization.* If a provider does not furnish any covered services to Medicare beneficiaries during a cost reporting period, it is not required to submit a full cost report. It must, however, submit an abbreviated cost report, as prescribed by HCFA.

(h) *Waiver of full or simplified cost reporting for low program utilization.* (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) and has received correspondingly low interim payments for the cost reporting period, the intermediary may waive a full cost report or the simplified cost report described in §413.321 if it decides that it can determine, without a full or simplified report, the reasonable cost of covered services provided during that period.

(2) If a full or simplified cost report is waived, the provider must submit within the same time period required for full or simplified cost reports:

(i) The cost reporting forms prescribed by HCFA for this situation; and

(ii) Any other financial and statistical data the intermediary requires.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 39829, Sept. 1, 1992; 59 FR 26964, May 25, 1994; 60 FR 33125, 33136, 33143, June 27, 1995; 60 FR 37594, July 21, 1995; 62 FR 31, Jan. 2, 1997]

Subpart C—Limits on Cost Reimbursement

§413.30 Limitations on reimbursable costs.

(a) *Introduction.* (1) *Scope.* This section implements section 1861(v)(1)(A) of the Act, by setting forth the general rules under which HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments, and sections 1861(v)(7)(B) and 1886(a) of the Act, by setting forth the general rules under which HCFA may establish limits on the operating costs of inpatient hospital services that are recognized as reasonable in determining Medicare program payments. (For cost reporting periods beginning on or after October 1,

1983, the operating costs incurred in furnishing inpatient hospital services are not subject to the provisions of this section.) This section also sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers.

(2) *General principle.* Reimbursable provider costs may not exceed the costs estimated by HCFA to be necessary for the efficient delivery of needed health services. HCFA may establish estimated cost limits for direct or indirect overall costs or for costs of specific items or services or groups of items or services. These limits will be imposed prospectively and may be calculated on a per admission, per discharge, per diem, per visit, or other basis.

(b) *Procedure for establishing limits.* (1) In establishing limits under this section, HCFA may classify providers by type of provider (for example, hospitals, SNFs, and HHAs) and by other factors HCFA finds appropriate and practical, including—

- (i) Type of services furnished;
- (ii) Geographical area where services are furnished, allowing for grouping of noncontiguous areas having similar demographic and economic characteristics;
- (iii) Size of institution;
- (iv) Nature and mix of services furnished; or
- (v) Type and mix of patients treated.

(2) Estimates of the costs necessary for efficient delivery of health services may be based on cost reports or other data providing indicators of current costs. Current and past period data will be adjusted to arrive at estimated costs for the prospective periods to which limits are being applied.

(3) Prior to the beginning of a cost period to which revised limits will be applied, HCFA will publish a notice in the FEDERAL REGISTER, establishing cost limits and explaining the basis on which they were calculated.

(4) In establishing limits under paragraph (b)(1) of this section, HCFA may find it inappropriate to apply particular limits to a class of providers due to the characteristics of the provider

class, the data on which those limits are based, or the method by which the limits are determined. In such cases, HCFA may exclude that class of providers from the limits, explaining the basis of the exclusion in the notice setting forth the limits for the appropriate cost reporting periods.

(c) *Provider requests regarding applicability of cost limits.* A provider may request a reclassification, exception, or exemption from the cost limits imposed under this section. In addition, a hospital may request an adjustment to the cost limits imposed under this section. The provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the provider of HCFA's decision. The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for a Board review, as specified in §405.1841 of this chapter. HCFA's decision is subject to review under subpart R of part 405 of this chapter.

(d) *Reclassification.* A provider may obtain a reclassification if it can show that its classification is at variance with the criteria specified in promulgating the limits.

(e) *Exemptions.* Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

(f) *Exceptions.* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An

adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

(1) *Atypical services.* The provider can show that the—

(i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and

(ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

(2) *Extraordinary circumstances.* The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.

(3) *Providers in areas with fluctuating populations.* (i) The provider is located in an area (for example, a resort area) that has a population that varies significantly during the year;

(ii) The appropriate health planning agency has determined that the area does not have a surplus of beds and similar services and has certified that the beds and services made available by the provider are necessary; and

(iii) The provider meets occupancy standards established by the Secretary.

(4) *Medical and paramedical education.* The provider can demonstrate that, if compared to other providers in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program specified in § 413.85.

(5) *Unusual labor costs.* The provider has a percentage of labor costs that varies more than 10 percent from that included in the promulgation of the limits.

(g) *Operational review of providers receiving an exception.* Any provider that applies for an exception to the limits established under paragraph (f) of this section must agree to an operational review at the discretion of HCFA. The

findings from any such review may be the basis for recommendations for improvements in the efficiency and economy of the provider's operations. If such recommendations are made, any future exceptions shall be contingent on the provider's implementation of these recommendations.

(h) *Adjustments.* For cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983, HCFA may adjust the amount of a hospital's inpatient operating costs to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services. Such factors could include a decrease in the inpatient services that a hospital provides that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A decrease in inpatient services could result from changes that include, but are not limited to, such actions as closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department.

[51 FR 34793, Sept. 30, 1986, as amended at 52 FR 21225, June 4, 1987; 53 FR 38533, Sept. 30, 1988; 60 FR 45849, Sept. 1, 1995]

§ 413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.

(a) *Principle.* A provider of services that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services described in § 413.30, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual. The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) such more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in which such charges are imposed exceeds the applicable limit imposed under the provisions of § 413.30. This charge may be made only if—